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To improve patient safety, you need to stay on top of best practices. That’s why, as shown by the 2011 numbers above, we provide you the risk management advice you need, when and how you want it. It’s why we provide industry-leading CME online and through Claims Rx, our monthly publication based on closed claims. And why we tailor solutions to help with your specific risk issues. The results include 98% policyholder retention, the highest-level CME accreditation and reduced risk for you.
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It is my HONOR to serve as your president of OPSC this year. 2013 promises to be an exciting year in medicine. The OPSC staff, under the direction of our executive director, Kathleen Creason, your OPSC Board, and I are committed to represent the OPSC membership and all osteopathic physicians in California to the best of our abilities. And, we will make every effort to keep you apprised of on-going changes through our website, our journal, and our availability via email, phone and in-person, especially at our conferences.

At our Annual Convention in February, AOA President Ray Stowers, DO and AOA Executive Director John Crosby, JD participated in a Town Hall to discuss the possible changes in Graduate Medical Education. OPSC will keep our website up-to-date on the latest information from the AOA regarding the proposed ACGME residency accreditation merger. You will find answers to FAQs on this topic there. We know there are a lot of questions and concerns, especially as it relates to maintaining our osteopathic distinctiveness. Our session in February was lively; we realized that we could easily have allotted another full hour to the topic. Our Fall Conference chair, OPSC VP John Kowalczyk, DO, has assured me there will be an update on the agenda. For the most current information, I would encourage all to view the video message from John Crosby in *The DO*, March 2013 edition.

Issues We’re Watching

- **OCC, Osteopathic Continuous Certification**, has begun in 2013. OPSC is committed to keeping you, the members, as current as we can on the information needed to maintain your certification. Our Education Committee has accepted the charge to ensure that our CME conferences address the needs of our osteopathic physicians. At our February Annual Convention, for the first time, we were able to record the lectures from one full day at the conference. This is STEP ONE for on-line CME. We hope to make an offer for remote CME later this year! After all, California has always been known for being at the forefront of so many things. OPSC is right there!

- **Maintenance of Licensure (MOL)** is an on-going topic. This is still in the early development phases. But, we do understand that the OMBC hopes to participate in a pilot project for MOL. OPSC is following this subject closely. And we will keep you informed!
Due to its popularity, the format of the Executive Director’s report will continue as a dialogue highlighting examples of representative activities and events in which OPSC is involved.

Monday

My typical Monday usually starts with a relatively quiet morning in the office, checking email, reviewing the week’s scheduled activities, and getting started on a project or two. This day quickly demonstrates that it won’t be a typical one. It starts out with a bang, with a 9:00 a.m. legislative hearing on the Osteopathic Medical Board of California (OMBC). We just found out a few days ago that the legislative consultant raised the question about whether the OMBC should be merged into the Medical Board of California (MBC). Due to California’s historic amalgamation with the MD profession in the early 1960s, there’s still a huge sensitivity in the osteopathic profession to the “M” word (merger). The pain of the 2010 addition of naturopathic doctors to the OMBC also still stings. We will not allow anything like that to happen again. First step – talk to the legislative consultant who proposed the idea. He explains that we’ve done such a good job of convincing the Legislature that DOs are equivalent to MDs, so a single licensing board seems like a natural step. By the end of the conversation, he understands our opposition. Next step – testify at the hearing. OPSC’s testimony, focused on the need for a separate osteopathic licensing board, seems to be well received by legislators. After the hearing – we schedule meetings with key legislative leadership to ensure the idea does not rear its head again. Throughout this process, we make sure to keep California’s DOs informed. We find nearly all DOs are vehemently opposed to the idea of a merged board, but interestingly there are a few vocal supporters.

The public testimony for the OMBC portion of the hearing finally began at 4:50 p.m. so it was a long day of waiting (thank goodness for email on iPhones!). However, the day is not over. An OPSC Legislative Committee conference call is scheduled to take place this evening. Chair Minh Nguyen, DO and I have been talking regularly with our legislative advocates, and we both attended the California Medical Association’s Council on Legislation the previous week, so we have a good amount of background information to share as the committee establishes its proposed legislative positions and priorities. The committee also talks about keeping the Key Contacts program moving along, so members can develop strong relationships with their legislators. The conference call concludes at 8:15, which leaves me with a little family time tonight.

Tuesday

Mid-morning on Tuesday, the Department of Health Care Services (DHCS) holds a meeting of key stakeholders as they seek input on a new Medi-Cal rule limiting physician visits. In its infinite wisdom, the Legislature has established a seven-visit annual maximum for Medi-Cal patients, unless a need for additional visits is documented. During the meeting, OPSC expresses strong concerns about potential reporting delays which could result in physician non-payment. DHCS staff agrees that this could be problematic and commits to working on a solution. Because DOs disproportionately serve needy patients, this is a real concern to OPSC members.

After the DHCS meeting, I head to our legislative advocate office for a luncheon fundraiser for new Assemblyman Rich Gordon. Oftentimes, I have to start from the beginning with new legislators, explaining what an osteopathic physician is. In this case, I’m very pleased to discover that Assemblyman Gordon is not only familiar with DOs, but he also has a good grasp of the role of the physician in health care delivery. How does he know this? His significant other is a physician! These types of meetings are so helpful, not only in exposing legislators to the osteopathic profession, but also gathering information that helps us develop legislative strategy.

Challenge to Members

An OPSC member who wished to remain anonymous has made a “Pay off the Mortgage” contribution of $1,000 – and he challenges all members to do the same! OPSC purchased our grand historic headquarters building in 2010 as an investment and as a visible means of promoting the osteopathic profession. While the building is valued at over $1 million, OPSC holds just a $300,000 mortgage. The interest paid on the mortgage would be better used for services to support members. Contributions may be sent to OPSC with the notation “OPSC Building Fund.”

Continued on page 32
As we enter spring, with its theme of re-birth, fresh energy and love, it seems a fitting time to introduce myself as the new editor of the *California DO*. A few details are in order, then we can get on with the show.

I’m a 2002 graduate of WUHS/COMP and completed a family practice residency at Chino Valley Medical Center. I spent six years in a private OMM practice in Chino, California, before accepting a full-time faculty position in the Department of NMM/OMM at COMP. I have been chair of the Education Committee of OPSC for the past two years and served on the OPSC Board of Directors from 2009–2012.

Now that we’ve gotten to know each other, I’ll share a little bit about my vision for this journal. Together with Alesia Wagner, DO, our current President, I am going to take us in a direction of more peer-reviewed, scientific articles. I plan to include case reports and original research being performed by our vibrant osteopathic profession here in the state and also by our amazing residents as part of their training programs. In coming issues look for unique, fascinating reports of patients to help us remember that sometimes those hoofbeats really are zebras.

Of course, the important reports from OPSC will continue as they have. I personally look forward to the Executive Director’s report each issue, as our superstar ED, Kathleen Creason, gives us an inside look to just what it takes to run a state organization. Important legislative updates will help continue to keep us up to date on the goings on in Sacramento that affect us all as a profession. The President’s Report also gives us an inside look at the key functioning of OPSC. And we’ll have updates from the two colleges as we continue to shape, mold, and educate the future of healthcare in California.

Finally, you might wonder why I mentioned love in the first paragraph. “That’s not the kind of talk I expect in a scientific journal,” you might say. But from my perspective, as a teacher and clinician, the love, respect, and care we show our patients is the highest reflection of the art of Osteopathy. I often share with my students one of my favorite quotes from Dr. Still from his autobiography. If I may, I’d like to share it with you as well:

“This is a war not for conquest, popularity, or power. It is an aggressive campaign for love, truth, and humanity. We love every man, woman, and child of our race, so much so that we have enlisted and placed our lives in front of the enemy for their good and the good of all coming generations[...]

Dr. Still

As OPSC welcomes a new editorial team to the *California DO*, please join us in sincerely thanking our outgoing editors: Bartley Yee, DO (Chair, 2010 – 2013) and Mohammed Jamshidi-Nezhad, DO (Vice Chair, 2011 – 2013).
Spring Legislative Update

Dave Helmsin and Jennifer Snyder, Capitol Advocacy

2013-2014 Legislative Session

The 2013 bill introduction deadline was February 22, and over 2,200 bills have been introduced. Many of these measures pertain to healthcare expansion, healthcare workforce, healthcare regulation and implementation of various program reforms. The Governor also called, and the Legislature convened, a special session on health care, which produced several measures dealing with Medicaid expansion and California Exchange implementation. Since this is the first year of a two-year session, bills introduced in 2013 will be viable through 2014.

For the first time since 1933, Democrats now hold a two-thirds majority in both houses of the Legislature — 29 Democrats out of 40 members in the Senate and 55 Democrats out of 80 members in the Assembly. With this new power, Democrats can raise taxes, control legislative rule making and place initiatives on the ballot without voter signatures. Governor Brown has made it clear he is not interested in additional taxes and many Democrats have also said that they will not abuse their new power. Thus, it remains to be seen what changes, if any, will result from the Democratic “super majority.”

State Budget Overview

Governor Jerry Brown released his 2013-14 State Budget Proposal on January 10. With the passage of Proposition 30 and extensive budget cuts over the past few years, California is facing a much smaller deficit than years past. Due to tax changes at the federal level, the state also generated $4 billion in extra revenue in January. The Governor is emphasizing fiscal constraint and using the windfall to pay off the state’s massive debts. His budget focuses on fiscal discipline and dealing with the state’s many unfunded liabilities. He is not inclined to restore any spending cuts made in health and human services program in the last three years. Nor is he interested in entertaining any additional new revenues beyond Proposition 30.

The budget did not propose the usual multi-billion dollar cuts to health care or other vital services. In addition, the Governor publicly endorsed California’s implementation of the Affordable Care Act and his commitment to Medicaid expansion, which brings in $204 billion in federal funds into the state’s health care system. Unfortunately, there were no proposed restorations to health and human services programs which have taken over $15 billion in severe cuts in recent years — including rate cuts to Medi-Cal providers, the elimination of dental benefits for adults in Medi-Cal, and absorption of programs such as Healthy Families into Medi-Cal.

Health Care Workforce

Senator Ed Hernandez has proposed a series of bills that are intended to address issues related to healthcare workforce shortages and patient access to healthcare services associated with the ACA. His legislation would expand scope of practice for optometrists, pharmacists and nurse practitioners. There are numerous other pieces of legislation that also attempt to partially address the physician shortage. OPSC is involved in discussions related to proposed legislation and plans to take an active role in responding to Senator Hernandez’s proposed legislation.

Bills of Interest to OPSC Members

OPSC is following a number of key bills on behalf of its members. As these bills approach their first policy committee hearing, they are likely to be amended. Other bills are also likely to morph into measures of interest to OPSC.

AB 565 (Salas) – California Physician Corps Program

This bill would require the guidelines for the selection and placement of program applicants to include criteria that would give priority consideration to applicants who have three years of experience providing health care services to medically underserved populations in a federally designated health professional shortage area or medically underserved area, and who agree to practice in those areas and serve a medically underserved populations.

AB 589 (Fox) – Medical Education: underrepresented medical specialties

This bill would establish a loan assumption program for physicians working full time in California practicing in underrepresented specialties, as defined. This program would provide loan assumption benefits to persons who agree to work full time for four consecutive years in California as physicians practicing in underrepresented specialties.

AB 1208 (Pan) – Medical Homes

This bill would establish the Patient Centered Medical Home Act of 2013 and would define a “medical home” and a “patient centered medical home” for purposes of the act to refer to a health care delivery model in which a patient establishes an ongoing relationship with a licensed health care provider, as specified.

SB 62 (Price) – Coroners: reporting requirements; prescription drug use

This bill would expand provisions to require a coroner to make a report when he or she receives information that indicates a death may
be the result of prescription drug use and to require the coroner to additionally file the report with the California State Board of Pharmacy.

**SB 266 (Lieu) – Health care coverage; out-of-network coverage**

This bill would prohibit a health facility or a provider group from holding itself out as being within a plan network or a provider network unless all of the individual providers providing services at the facility or with the provider group are within the plan network.

**SB 381 (Yee) – Healing arts; chiropractic practice**

This bill would prohibit a health care practitioner from performing a joint manipulation or joint adjustment, as defined, unless he or she is a licensed chiropractor, physician and surgeon, or osteopathic physician and surgeon. The bill would provide that a health care practitioner who performs a joint manipulation or joint adjustment in violation of these provisions engages in the unlawful practice of chiropractic, which shall constitute, among other things, good cause for the revocation or suspension of the health care practitioner’s license.

**SB 410 (Yee) – Health care; controlled substances and dangerous drugs**

Current law requires the physician and surgeon to exercise reasonable care in determining whether a particular patient or condition, or complexity of the patient’s treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist. This bill would specify that chronic pain is included among the types of pain for which these drugs or substances may be prescribed.

**SB 491 (Hernandez) – Nurse Practitioners**

This bill intends to address the practice of nurse practitioners and expansion of patient care.

**SB 492 (Hernandez) – Optometric corporations**

This bill intends to address the practice of optometry and related areas of optometry practice.

**SB 493 (Hernandez) – Pharmacy Practice**

This bill intends to address the licensing and regulation of pharmacists related to expanding their ability to provide patient care.

**SB 809 (DeSaulnier) – Controlled substances; reporting**

This bill would establish the Controlled Substance Utilization Review and Evaluation System (CURES) Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

**State’s Implementation of the ACA**

**Medicaid Expansion**

In the health care special session, the Legislature is deliberating over Medicaid expansion to cover all legally residing Californians under 138% of the federal poverty level. Currently, the Medi-Cal programs cover children, parents, seniors and people with disabilities, but not many adults without kids. The ACA asks states to pay for 5% of the cost of coverage in 2017 and 10% in 2020 and beyond. The Governor is looking to counties to share in the responsibility and potential cost of this expansion. The counties, the Legislature, consumer advocates, and many other key stakeholders are not in favor of the risk sharing by counties.

Under the ACA, some low-income individuals will transition back and forth between Medi-Cal and private insurance. The Governor is proposing to establish a Medicaid Bridge Program, which will ensure that these individuals remain with the same insurance plan and provider network. The Legislature would like to see a broad array of services provided to Medi-Cal beneficiaries in this program while the Governor would like to limit these services. In addition, the ACA requires Medi-Cal expansion to those already eligible through enrollment and eligibility simplifications. The Governor proposes $350 million to fund these related program changes.

**Medi-Cal Managed Care Expansion**

California is still planning to implement its Coordinated Care Initiative, which will move 560,000 Medi-Cal and Medicare dual eligible beneficiaries from fee-for-service to managed care beginning 2013-2014. Under the CCI, dual-eligibles will receive medical, behavioral health, long-term supports and services, and home and community-based services coordinated through a single health plan. Previously, the CCI was scheduled to start March 2013 in all demonstration counties (Los Angeles, Orange, San Diego, San Bernardino, Riverside, Alameda, and Santa Clara). The Governor proposes to push out implementation of the initiative to September 2013 with Los Angeles County implementing over an 18-month period. So far the Memorandum of Understanding between the federal government and the state required to implement the program has not been signed. As of March 18, the MOU was still being negotiated between the state and CMS.
Medi-Cal Provider Rate Cut

The U.S. Court of Appeals for the Ninth Circuit ruled in December 2012 that California can cut rates to Medi-Cal providers by 10%. The plaintiffs, including the California Medical Association (CMA) have appealed this decision and requested an “en banc” review by an 11 judge panel of the Ninth Circuit.

In addition to providing financial support of the lawsuit, OPSC is working with the CMA on legislation to eliminate the 10% Medi-Cal provider rate cuts in statute. A coalition of providers is also asking that the Legislature and the Governor reconsider the previous cuts to Medi-Cal provider rates in light of health care reform and the need for access to health care services by qualified providers.
CASE STUDY

A Rapidly Fatal Case of *Balamuthia Mandrillaris*

Victoria Hsiao DOR3, Family Medicine Residency, Chino Valley Medical Center

**CHIEF COMPLAINT:** 16-year-old Hispanic male presented to the emergency department with complaints of fever, headache and confusion.

**HISTORY OF PRESENT ILLNESS:** Upon arrival to the emergency department, the patient was altered, thus medical history was obtained from the mother. Over the past week and a half patient complained of intermittent headaches and fevers. Mother states that a week and a half prior to his headaches, he was spending time with a friend making preparations for a birthday party. Patient's mother did not notice any unusual behavior when her son returned, with no evidence of drug or alcohol use. The following day the patient's headaches progressively worsened over the next week. There were also reports of intermittent bouts of abdominal pain and nausea.

Two days prior to arriving at the ER, the patient was seen by his primary care physician and started on ibuprofen and azithromycin 250mg for an upper respiratory infection. Patient developed severe headache the next two days for which he took diclofenac, thiamine, pyridoxine and B12 with minimal relief.

A day prior to presentation, the patient had complaints of dyspnea. He became altered that evening and developed an imbalance in his gait. He became agitated and was unable to speak and began mumbling, which prompted his mother to bring him to the emergency room.

**ALLERGIES:** no known allergies

**PAST MEDICAL HISTORY:** No history of cardiac disease or thyroid disease. No prior history of strokes, tuberculosis, or diabetes.

**PAST SURGICAL HISTORY:** No prior surgical history.

**FAMILY HISTORY:** Denies cardiac disease, stroke, thyroid disease, cancer, and tuberculosis or blood disorders.

**SOCIAL HISTORY:** No reports of tobacco, alcohol or illicit drug use. Patient is not sexually active. Patient lives at home with his parents. He is currently a student in high school.

**PHYSICAL EXAMINATION:** Vital Signs (blood pressure 119/61, temperature 98.1 degrees, pulse 95, respiratory rate 18, O₂ saturation 98% on room air, height 66 inches, weigh 68 kg, BMI 24) were within normal limits. Patient was a 16 year old Hispanic male who was well developed, well nourished and well hydrated. Patient was alert and able to state his name, however not oriented to person or place. A thorough physical examination was performed which revealed that he was unable to follow commands and he was increasingly agitated. Pupils were equal and reactive. Neurological exam revealed mild disorientation and confusion. Patient had spontaneous movements of the upper and lower extremities. Negative for clonus or Babinski sign; cranial nerves II-XII intact. Reflexes are intact bilaterally of the upper and lower extremities 2/4. Gait and cerebellar exams were unable to be performed secondary to patient’s agitation and difficulty with cooperation.

**WORK UP:** While in the ER, routine blood work was performed including Chem 10, CBC, ammonia level, alcohol level, urine drug screen, acetaminophen and aspirin level. Additionally, a CT scan of the head was performed without IV contrast.

**DIFFERENTIAL DIAGNOSIS:** Upon admission, his differential diagnoses included polysubstance drug abuse, cerebrovascular accident, metabolic encephalopathy, toxic encephalopathy, encephalitis or meningitis possibly viral versus bacterial, or multiple cerebral pyogenic abscesses.

**HOSPITAL COURSE:** Patient was admitted and prophylactically started on intravenous rocephin, vancomycin and acyclovir for bacterial versus viral bacterial encephalitis/meningitis. After evaluation by infectious disease, patient's antibiotics were changed to ceftriaxone and metronidazole intravenously. The patient never developed a white count or bandemia. Initially there was a mild elevation in neutrophils and low lymphocyte count, which slowly resolved.

Neurology was consulted for further recommendations. Patient’s alcohol level was 0, urine drug screen was negative as well as acetaminophen and aspirin levels. Lumbar puncture was obtained and sent out for cell count, differential, glucose, protein, cysticercosis, gram stain and culture as well as a bacterial antigen panel. Initial CSF fluid showed elevated WBC 107, RBC 26, lymphocytes 99 and protein at 96.4. CSF glucose was within normal limits at 40. Gram stain at that time was negative as was the CSF culture. The CSF was also sent out for Haemophilus Influenza B antigen, Strep Pneumoniae antigen, Group B Strep Ag and Neisseria Meningitidis antigen which all return negative. A repeat spinal tap was performed three days after the initial spinal tap. Results then revealed WBC elevated at 300, RBC 5.6, and protein of 96.7. CSF glucose was low at 32. CSF fluid was further analyzed by ELISA for IgG for Cysticercosis which returned a
level of 0.09 which is considered negative. Fungal analysis returned a negative smear and negative culture. India ink stain also showed no yeast growth. Additional testing was performed per infectious disease recommendations including Cryptococcus antibody, Toxoplasma IgG and IgM; all resulted in negative results.

Multiple imaging studies were performed during the patient’s hospital stay. On admission, CT scan of the head without contrast showed focal hypodensities in the right and left hemispheres adjacent to the lentiform nuclei, etiology uncertain. MRI of the brain without contrast done on day of admission showed numerous rim enhancing lesions throughout the bilateral cerebral and cerebellar hemispheres including the deep gray nuclei with associated edema. Lesions noted on MRI were found to measure from 1.3 cm x 0.8 cm to 1.0 cm x 1.8 cm. Repeat imaging was performed three days after patient’s day of admission due to lack of response to treatment. CT scan of the head with IV contrast showed continued numerous hypodense lesions throughout the cerebral and cerebellar hemispheres bilaterally. Repeat MRI showed consistent findings similar to the previous study.

The patient continued to remain stable with no response to antibiotics. Infectious Disease and Neurology agreed that brain biopsy was essential for further investigation and treatment. Patient was then transferred to a higher level of care.

**FOLLOW-UP:** There was limited information on patient’s follow up as he was transferred to Children’s Hospital of Orange County for further work up. A brain biopsy was obtained in which patient was discovered to be infected with *Balamuthia Mandrillaris*. The Center for Disease Control and Prevention became involved with the case. Patient expired shortly thereafter.

**DISCUSSION:**

There have been over a hundred incidences of *Balamuthia Mandrillaris* since it was first isolated from a Mandrill Baboon at the San Diego Wild Animal Park. Thought to be a free-living amoeba, it has been it has been known to cause Balamuthia amoebic encephalitis not only in humans but in other species as well. Patients infected with Balamuthia present with a wide range of symptoms that mimic other causes of encephalitis, making it extremely difficult to diagnose. Some common symptoms include headaches, dizziness, seizures, fevers, visual disturbances, confusion, as well skin lesions. This case focused on a 16-year-old male from San Bernardino County who presented with confusion, gait disturbances, HA and was found to have multiple ring enhancing brain lesions on MRI.

*Balamuthia Mandrillaris* was previously only isolated through autopsies of the deceased, however advances in the past decade have isolated this amoeba from the environment. (Schuster et al, 2003) Although many cases have been reported worldwide, in the United States it is predominantly found in the southern aspects of California, Texas, Georgia and Florida. There is increasing evidence that Balamuthia is preferential towards warmer climates. This amoeba is can be found in stagnant water but more commonly in soil (Martin et al, 2008). From the limited data that is available, there is an inclination towards those of the male gender as well as those of the Hispanic population. It is unclear whether this is secondary to socioeconomic factors and employment opportunities in which the majority of the workforce in agriculture is of Hispanic descent. (Schuster et al, 2004) In addition, males are more commonly employed within the agricultural industry as opposed to women. A second hypothesis is that those of Hispanic descent may have genetic differences rendering them incapable of...
making the antibodies against certain ameobic infections. (Chappell et al. 2001). In this case the patient was of Hispanic descent, living in Chino, California; he did not work in agriculture, although there were also reports of outdoor gardening activities and playing with his pets that occurred prior to the onset of his symptoms.

Transmission most commonly occurs through the nasal mucosa into the respiratory tract or through a break in the skin (Maciver, 2007). Once the amoeba enters the body it invades the central nervous system causing an assortment of neurological symptoms. It is presumed that the patient may have contracted the disease while outdoors during the summer months. On examination there were no noted breaks in his skin and the patient never showed any cutaneous manifestations, therefore it is highly likely that the amoeba invaded his central nervous system through the respiratory tract.

The diagnosis of Balamuthia Mandrillaris continues to be extremely difficult to detect as it affects both those who are immunocompromised as well as immunocompetent individuals with little evidence of predisposing factors. There are a whole host of symptoms that may manifest as Balamuthia amebic encephalitis (BAE) when the central nervous system is infected. Some early symptoms of BAE are headaches, neck pain, photophobia, nausea, vomiting, fatigue and low grade fevers. As the disease progresses, the symptoms may worsen to include behavioral changes, seizures, partial paralysis, speech difficulties and changes in gait and coordination. (Perez MT et al, 2007) In those who contract B. mandrillaris through a skin infection, the typical presentation begins as an asymptomatic granulomatous plaque commonly located on the central face. As the infection spreads, multiple lesions may develop and spread to the extremities which can be complicated by ulcerations in later stages (Lupi O et al. 2009). Symptoms may be mild in the first few weeks however can progressively worsen within a period of weeks to several months. With our patient, his initial presentations included intermittent headaches as well as low grade fevers for 1.5 weeks. By the time he presented at the ER, he had developed an altered level of consciousness and speech deficits, as well as gait instability. Studies have shown mild symptoms may be present for months prior to any physician contact. Patients commonly present with severe symptoms for six to eight weeks prior to mortality (CDC, 2008). Our patient had a rapid progression of the disease in comparison to previous reports of those who have expired. He continued to have worsening neurological impairments throughout his hospital stay and expired thirty-six days after his initial presentation of headaches.

There have been significant advances in the ability to specifically detect Balamuthia Mandrillaris in those with BAE. In the past, those infected with BAE underwent brain biopsies in which the brain tissue was further analyzed under indirect immunofluorescence microscopy. This required significant expertise to obtain an accurate brain tissue sample therefore it was a very unreliable test. (Kiderlen et al. 2007) Now with recent improvements in scientific research, real time PCR can be used to detect the Balamuthia Mandrillaris. Real time PCR provides a much more specific, sensitive and reliable test of choice to analyze larger sample to target a specific ribosomal RNA gene sequence. (Tavares M et al. 2006). This assay allows health professionals to accurately detect B. Mandrillaris apart from other pathogens including Acanthamoeba, toxoplasma gondii, leishmania major, mycobacterium bovis, and many others (Kiderlen AF et al. 2008). This allows specific detection of those infected with BAE so that early treatment may be initiated. Although our patient may have benefited from early testing with real time PCR, the problem continues to be early detection by health professionals. It is important that physicians become aware of this disease so that specific work up can be initiated in those who have a high suspicion for infection.

Although it is unclear whether medications such as antibiotics, antifungals, or antiprotozoal are effective, early recognition may provide an opportunity to initiate treatment that may slow or stop the progression of the disease. There is no cocktail of treatments that has proven to be effective. However, in the few who have survived, multiple antimicrobial combinations have been given. Data accumulated in 2010 report seven survivors of B. Mandrillaris in the world, four of which have been reported in the United States and of those four, three from California (Martinez DY et al. 2010). Common medications for those in California included a regimen consisting of flucytosine, fluconazole, pentamidine isethionate, sulfadiazine and a macrolide. Of those survivors in California, treatment was given for a period of months to 2.4 years. The patients who have survived were able to return to full function in activities of daily living without gross neurological sequelae (Deetz TR et al. 2003). In our patient, initial treatment included a course of azithromycin by his primary care physician. During his course at our hospital intravenous treatments of cephalxin, vancomycin, metronidazole, and acyclovir were initiated. Although antibiotics were initiated, he continued to have progressive neurological symptomology throughout his hospital stay.

Of the documented cases of B. Mandrillaris, there is a 98% fatality rate of those who present with BAE. (Siddiqui R et al. 2008) There have been 11 cases in California alone in the past decade, 9 of which have been fatal (Noah DL et al. 1998). Even with new advances in
For the last 25 years I have had the privilege of collaborating with some of the finest primary care physicians when it comes to our mutual patients – but the times are changing. No, it isn’t the quality of the primary care physicians that has changed. No, it isn’t my willingness to collaborate that has changed. It is the availability of publicly-funded mental health services that has changed.

Within the community mental health system, there have been “excluded” diagnoses from the time I first entered a county mental health clinic in 1990. These excluded diagnoses were appropriate because they were diagnoses better served by other agencies or diagnoses that don’t represent a major mental illness. That was the way it remained until approximately four years ago when “excluded” diagnoses were expanded to encompass the vast majority of psychiatric diagnoses. In response to budget cuts, I found myself working only half of the hours I was used to. In order to make the patient population “fit” into that reduced availability of psychiatric services, the “excluded” diagnoses were greatly expanded.

I realize that I am speaking of my experiences here in central California and things maybe different where you live. These may be changes that arrived in your area several years ago or they may be hiding over the horizon and have yet to be implemented. Nevertheless, I awoke to new rules – as a psychiatrist I can only medicate patients with major depression, bipolar illness, or psychosis (and in some counties PTSD). If a patient presented with an excluded diagnosis, then they were referred to their primary care physician. This means that I was referring patients with panic disorder, OCD, eating disorders, borderline personality disorder – you get the idea.

This created an ethical dilemma that drove me into private practice. That has been good for me – it means that I have returned to the “good ol’ days” of collaborating with primary care. It doesn’t change the reality of what you do (or will) face as a primary care physician.

Because of the increasing frequency with which you are asked to see these psychiatric cases, I feel compelled to provide some basic guidelines that I would like to see practiced in the primary care setting – especially if those cases are ultimately being referred to me. In that context, please note that these are intended to be simple “guidelines” that are easy to remember and use. If we

CONCLUSION:

_Balamuthia* Mandrillaris* is an emerging amebic infection that presents with a broad range of complaints in those who are immunocompromised as well as immunocompetent. Recognizing this illness early on and providing broad spectrum antibiotics may improve mortality rates. Physicians should consider Balamuthia amoebic encephalitis in patients who present with nonspecific neurological complaints in which no source can be found. Also it is important have a high index of suspicion in patients of male gender and Hispanic descent. With continued research and improving in diagnostic modalities as well as therapeutic interventions, patients diagnosed may have a better prognosis for survival. As we move towards the future, there should be ongoing education for health professionals to improve early suspicion for the disease. ■

References available upon request.

Basic Guidelines for the Management of Psychiatric Symptoms in the Primary Care Setting

 Bradley T. Wajda, DO
Management of Psychiatric Symptoms
Continued from page 11

all wanted to sit back in our ivory towers (I have a spare if you need one) to discuss this, we could undoubtedly complicate this beyond anything reasonably usable.

First, if the patient is a danger to himself/herself, a danger to others, or gravely disabled (impaired so severely as to be unable to care for themselves) – then call 911 and keep them safe until services arrive.

The fasting labs I like to see are: CBC w/diff, Comprehensive Chemistry (21 or 24), TFTs, lipids, B12, folate, Vitamin D25, Cortisol, UA, urine drug screen, and an EKG (if under 16, over 65, or when there is known cardiac disease). Use these results to screen for medical problems responsible for the psychiatric symptoms.

If you are not referring the case on to a psychiatrist (or don’t have that option) then certainly refer the patient to a therapist. The reasons for this are multiple – from establishing an accurate diagnosis to addressing symptom recognition and management.

Regarding polypharmacy – there shouldn’t be a reason for the patient to be on two (or more) medications from the same category (antidepressants/antipsychotics/mood stabilizers/anxiolytics) unless you are transitioning them from one medication to the other. Always stick to medications that you are familiar with. Because it is important for you to use medications you are already familiar with, I am not using this opportunity to do a basic review of psychiatric medication.

If the patient is hypomanic or manic – immediately refer to psychiatry. These cases can deteriorate very rapidly. In the meantime use an antipsychotic, benzodiazepine, or both as a stopgap measure. Mood stabilizers take time to work and wouldn’t be considered for an acute intervention – they can be started but with the intent of providing maintenance therapy later.

Mood Swings:

Bipolar illness is both over-diagnosed and misdiagnosed. Rapid mood swings (occurring faster than every four days) are NOT bipolar illness. Unfortunately, even clinicians consider these as “rapid cycling” bipolar mood swings. Rapid mood swings are “affective instability” and caused by personality disorders, substance abuse, medication side effects, or underlying medical issues. “Rapid cycling” as applied to bipolar illness means four or more cycles in a year. By definition hypomanic episodes must last at least four days, mania at least one week, and depression at least two weeks to qualify for bipolar illness. Even one bona fide manic episode (absent underlying medical issues) means that the patient is bipolar.

Depression:

Use agents that you are familiar with and stick to monotherapy. Review the labs for underlying medical causes and refer to a therapist if not to a psychiatrist. If you suspect that the patient has bipolar illness DO NOT prescribe an antidepressant – it can activate them into a mania. There are only two medications for bipolar depression – Symbyax and Seroquel.

Anxiety:

Don’t start the patient on a long road of benzodiazepine use. Stick to antihypertensives and antidepressants (obviously avoid specific medications that are clinically contraindicated by other medical conditions). Review the labs for medical causes.

Anger:

The severity of the anger will direct whether you use mood stabilizers, antihypertensives, or antidepressants (again using medications you are familiar with and avoiding specific medications that are clinically contraindicated by other medical conditions). Benzodiazepines should be a tertiary choice and review the labs for medical causes.

Psychosis:

Immediately refer to psychiatry. Use antipsychotics that you are familiar with and look for underlying medical issues.

Always err on the side of being conservative – whether applied to calling 911 or sending the case to the ER. Don’t feel compelled to treat what you are not comfortable with. Maybe by pushing back against the tide of unreasonable demands that primary care physicians function as psychiatrists we can change the current.
Dear colleagues…It has been a quite a dynamic year for all of us – with numerous changes in how we practice medicine. We are continuously tackling new challenges. While defending our rights to practice medicine unfeated, osteopathic physicians must preserve the integrity of the unique brand of medicine we bring to our patients.

It has been four years since naturopathic doctors were placed on our Osteopathic Medical Board. As a result of this affront to our identity as fully licensed physicians, three years ago OPSC saw its greatest increase in membership. In addition, our membership mounted a groundswell of advocacy and involvement to fight and repeal this incorporation. Thanks to the stalwart efforts of our members and our allies in the Legislature, this merger was nullified by the passage of SB 1050. Our medical board is once again comprised exclusively of osteopathic physicians as professional members.

It gives me great confidence to know that when we need to rally support, our members are willing to work relentlessly to advocate the positions of OPSC. It is only through our uncompromising vigilance that we are literally still able to exist as a profession. I wish all our fights were won, and that our fate was secure and unchallenged. However, we cannot ignore the continuous assaults and underhanded tactics by multiple entities to denigrate and weaken the medical profession as a whole — and more specifically, osteopathic medicine.

As this article was being written, our licensing board underwent a customary “sunset review.” A question arose about whether the Medical Board of California and the Osteopathic Medical Board of California should still operate as separate legal regulatory entities. In the spirit of fiscal conservancy (a.k.a. budget cuts) a proposal was made to merge both osteopathic and allopathic medical boards into one combined governing body.

History is Repeating Itself

For those of us who did not experience the original battle, it was ingrained into our memories during medical school. It is THE founding reason why OPSC was created. As a result of the infamous 1962 merger, this organization has grown into a force to be reckoned with in Sacramento. From the early years of re-establishing our presence in California, to our present-day fight to continue practice in our present capacity, our resolve is stronger than ever before. We view the word “merge” with a heavy dose of skepticism and an overabundance of caution. Under the leadership of President Alesia Wagner, DO, we are firmly opposed to this proposal.

What Can You Do?

The question is whether you will fight to keep your right to practice in California without the onus or connotation of being considered “second tier.” What are you willing to do to help? Can you make a financial donation? Can you join us in active advocacy? If asked, will you write a letter to your state senator or representative supporting our position?

Will my resident and student members, who have the most at stake should this merger occur, tell fellow DOs and OMS classmates about this latest battle? Will you urge them to join our organization and support our cause when they graduate, further enriching our collective future? Will you be there for us so we can continue to be there for you?

There can be no compromise on these issues which strike at the core of who we are and what we do. You will hear skeptics say that we are exaggerating — that combined DO/MD medical boards have worked well in other states. Ask them: “When was the last time the MDs on those state medical licensing boards tried to eradicate the DOs in that state?”

Never again.

The fight is now. Are you in?
The following is an excerpt from the Color and Healing White Paper researched and written by Laura Guido-Clark Design, LLC on behalf of KI and Pallas® Textiles. The excerpt was made available by Pam Kruger, KI sales specialist and representative for the exclusive Interior Design and Furnishings Program for OPSC, which offers healthcare furnishings and textiles as well as interior design and installation services at a factory-direct all-inclusive price. For complete details of the program, visit ki.com/opsc.

Color is a powerful medium that can stimulate positive emotional reactions, which promotes conditions for recovery. There are several factors involved in creating an environment and color is an important component. There is a great deal of research that links physical environments in hospitals to health outcomes. According to Ulrich and Zimring, authors of the 2004 report, “The Role of the Physical Environment in the 21st Century Hospital,” there are now more than 700 credible studies that link healthcare design and its influence in medical outcomes.

Despite the varying research, we believe we can engage in a color dialogue and the way we use it within healthcare environments. It is clear that color can be used as a powerful tool and can provide interesting breaks from the expected neutral palettes of the past.

The impact of color far exceeds aesthetics. “The truth is,” states British color psychologist Angela Wright, “that color affects us physiologically as well as emotionally.” Since color stimulates the nervous system, it can influence mood and provoke reactions. As a consequence, the use of color can make environments more peaceful and less anxiety provoking. This translates into a positive mood, which encourages the healing process.

Color Application and Healing

Over the centuries, many cultures employed color for its healing powers. Egyptians designed chambers to produce a ray of prism light for healing the sick. In the Indian culture, each color is assigned to energy centers in the body. The field of Chromotherapy uses color as a therapeutic tool for treatments.

The Coalition for Health Environments Research conducted a study to determine what is really known about color influence. It concluded that the study of color in healthcare settings is challenging because it occurs in the context of meaningful settings and situations where personal perception and judgment come into play. This is further influenced by physiology, culture, time and location.

While scientists, designers and healthcare professionals agree that color can have an effect, it should not be viewed as a simplistic remedy. There are many other factors that must be considered when selecting healthcare colors such as the generational preferences and needs of the patient as well as the physiological perception of the aging eye.

Being familiar with the meaning of color and its impact on emotions provides the basis to engage in a color dialogue and the way in which color can be used as a powerful tool to enhance the healing environment. For example:

- In the Radiology suite, colors can be used to positively influence patient mood and promote relaxation. Colors can drape the clinical environment and technologies in a friendly, soothing light, easing fears and making the examination procedure less intimidating. This colorful approach can be extremely helpful when dealing with patients who are anxious or claustrophobic. Since a calmer patient moves less, the risk of possible motion artifacts will be reduced, contributing to a higher imaging quality.

- In pediatric environments, soothing yet interesting colors communicate a safe, warm place, while brightening dispositions and acting as stress relievers for both children and their caregivers.

- Finally, in elder care, the use of color is especially important when considering the impact of age on vision acuity. In these kinds of environments, the use of light, warm colors is recommended as well as yellow, orange and red in poorly lit conditions to provide points of focus.

- The Society of Critical Care Medicine recommends using calming colors that promote rest in critical care units (Fontaine et al., 2001). Blues, greens and violet are appropriate, because they have healing and calming influences and are stress-reducing colors. Reds, orange and yellow colors should be avoided, because they induce excitement, increase blood pressure and can cause fatigue (Starkweather et al, 2005).

Color by Nature

KI and Pallas® Textiles have researched color to develop a deeper, holistic understanding of its power in healing and the healthcare environment. The following overview summarizes the meaning and
effect of each color group relative to emotion, the body and healing – from our research and a Western perspective.

**Light Cool Neutrals – Clean, pure**

It can connote mental clarity. Overall, white projects cleanliness and purification. Gray is a true neutral and can be restful. It can create a noninvasive feeling and can cool more vibrant colors.

**Dark Cool Neutrals – Clean**

Black is authoritative and can evoke a feeling of mystery or emptiness.

**Earth Tones / Light and Dark Neutrals – Grounding**

All warm earth tone colors such as grays, beiges, browns, etc. ground you and help you feel sedentary and stable. The earth tone color family is approachable and warm, familiar and soothing.

"Research reveals people make a subsconscious judgment about a person, environment or product within 90 seconds of initial viewing and that between 62% and 90% of that assessment is based on color alone."

CCICOLOR: Institute for Color Research

△ AtlantiCare Regional Hospital uses elements of reds and oranges tempered with cool neutrals. KI product pictures is Soltice® and Impress Ultra® seating.

◆ Wabash General Hospital uses a palette of cool neutrals for a bright exam area. KI products featured include Versa™ bariatric seating and Dante™ casegoods.

A blue-hued privacy curtain supports a calm, relaxing environment. Pallas® Textiles Valetudo cubicle curtain is featured. ▲

Wabash General Hospital used earth tones for a warm, welcoming reception area as well as bright, fun colors in the children’s area. KI products pictured include Soltice® and Intellect Wave® seating. ▼
Welcome New Members!

**Active**

Robert A. Armada, DO, Obstetrics & Gynecology, Upland, CA  
Jeffrey Bergeson, DO, Orthopedic Surgery, Auburn, CA  
Edward Birdsong, DO, Family Practice, Soledad, CA  
Mary Bos, DO, Orthopedic Surgery, Manhattan Beach, CA  
Audra Buddde, DO, Poway, CA  
Marcelo A. Burciaga, DO, San Dimas, CA  
Kam Chan, DO, Family Practice, Vacaville, CA  
Winnie Chang, DO, Emergency Medicine, Fontana, CA  
George Chen, DO, Family Practice, San Luis Obispo, CA  
Christina Chow, DO, Pediatrics, Palo Alto, CA  
Christine Clotfelter, DO, Family Practice, Encinitas, CA  
Jacquelyn D. Cortez, DO, Obstetrics & Gynecology, San Diego, CA  
Vienn Doan, DO, Riverside, CA  
Hessam Eftekhari, DO, Anesthesiology, Riverside, CA  
Donald Fields, DO, Fresno, CA  
Bruce Flagg, DO, Osteo Manipulative Medicine, San Francisco, CA  
Julianne Harrison, DO, Los Angeles, CA  
Micheal Herrera, DO, Emergency Medicine, Lodi, CA  
Oksana Hiriak, DO, Family Practice, Carlsbad, CA  
Louis Ho, DO, Family Practice, Long Beach, CA  
Jeff Howell, DO, Geriatrics-Internal Medicine, Redlands, CA  
Ryan Hudson, DO, Family Practice, Bakersfield, CA  
Quinn Hume, DO, Anesthesiology, La Mesa, CA  
Joanne P. Keenan, DO, Internal Medicine, San Diego, CA  
Tarin Koehler, DO, Family Practice, Playa del Rey, CA  
Rebekah Latham, DO, Emergency Medicine, Auburn, CA  
Tuyet Lather, DO, Family Practice, San Diego, CA  
Sheik Latif, DO, Vascular Surgery, Hanford, CA  
Edward Markus, DO, Neurology, Irvine, CA  
Virginia Meade, DO, Neonatal-Perinatal Medicine, Santa Rosa, CA  
Astrid Mendoza, DO, Obstetrics & Gynecology, Torrance, CA  
Gita D. Meshri, DO, Obstetrics & Gynecology, Eureka, CA  
Mansour Mofidi, DO, La Mesa, CA  
Michelle Mouri, DO, Emergency Medicine, Redlands, CA  
Victor Nuno, DO, Osteo Manipulative Medicine, Vallejo, CA  
Raena Olsen, DO, Internal Medicine, Los Angeles, CA  
Kyle Owen, DO, Psychiatry, Walnut Creek, CA  
Sharlene Persaud, DO, Internal Medicine, Pasadena, CA  
Katrina Platt, DO, Internal Medicine, Pomona, CA  
Juanito Pontejos, DO, Internal Medicine, Petaluma, CA  
Stephanie Rade, DO, Internal Medicine, Sherman Oaks, CA  
Mark Roback, DO, Family Practice/OMM, Fortuna, CA  
Charles Rocambo, DO, Emergency Medicine, Los Angeles, CA  
Steven Rudolph, DO, Psychiatry, Palm Desert, CA  
James Scalone, DO, Orthopedic Surgery, San Diego, CA  
Douglas Slabaugh, DO, Emergency Medicine, Whittier, CA  
Kim Stafford, DO, Family Practice, Foster City, CA  
Joel Stillings, DO, Emergency Medicine, Colton, CA  
Renata Swanston, DO, Pediatrics, Moreno Valley, CA  
Kenneth Takaki, DO, Emergency Medicine, Brea, CA  
Amy Thomas, DO, Anesthesiology, Los Alamitos, CA  
John Thompson II, DO, Family Practice, Cameron Park, CA  
Veronica Tilden, DO, Osteo Manipulative Medicine, Grass Valley, CA  
Charles Trammel, DO, Internal Medicine, Cupertino, CA  
Sherri Tysh, DO, Oak Park, CA  
Lisa Valle, DO, Obstetrics & Gynecology, Marina Del Rey, CA  
Michele Vargas, DO, Emergency Medicine, Duarte, CA  
Micah Wittler, DO, Emergency Medicine, San Bernardino, CA  
Sengkham Wu, DO, Family Practice, San Diego, CA

**Associate**

Ibrahim Chehimi, DO, Family Practice/OMT, Hawalli, Kuwait  
Paula Crone, DO, Portland, OR  
Pat Marshio, DO, Abdominal Surgery, Fulton, TX  
Seth Bernard, DO, Family Practice, Flint, MI  
Rick Carpenter, DO, Ophthalmology, Hilo, HI  
Sobia Hasan, DO, Family Practice, Chicago, IL  
Philip Marinelli, DO, Neonatal-Perinatal Medicine, Denton, TX

**Intern**

Erandhi Hall, DO, Family Practice, Long Beach, CA

**Military**

Billie Park, DO, Family Practice, Yuma, AZ

**Resident**

Kieron Barkataki, DO, Emergency Medicine, Bakersfield, CA  
Adam Colton, DO, Franklin, MI  
Jared Heimbigner, DO, Radiology, Katy, TX  
Jaskarn Johl, DO, Ophthalmology, Fontana, CA  
Hana Kim, DO, Loma Linda, CA  
Sapna Mehta, DO, Internal Medicine, Calabasas, CA  
Vincent Wong, DO, Family Practice, Anaheim, CA  
Jennifer Young, DO, Family Practice, Chicago, IL  
Zachary Zwolak, DO, Family Practice, Salinas, CA

**Retired**

Robert Bornstein, DO, Pacific Palisades, CA  
Denise Cantin, DO, Family Practice/OMT, Holyoke, MA  
Katherine Mayo, DO, Obstetrics & Gynecology, North Tustin, CA
OPSC kicked off the 2013-2015 CME cycle with a very successful 52nd Annual Convention & Exposition. Held February 6-10 at the Hyatt Regency Mission Bay in San Diego, this year’s event drew over 500 participants for five days of educational sessions, three days of exhibits, and the 2nd Annual Career Fair.

Program Chair Alesia Wagner, DO labored diligently, with support from the Education Committee, led by Brian Loveless, DO, to produce over 35 hours of quality educational programming. But that was not the only success. Here are some other highlights:

- The Exhibit Hall showcased more than 20 medical groups and companies.
- The 2nd Annual Career Fair featured 10 companies looking to recruit DOs, including two who also exhibited.
- More than 80 convention attendees registered to participate in the Career Fair educational course.
- Eleven DOs received OPSC Awards.
- OMT Treatment Education Sessions returned, with 8 hours of open education times available for those wishing to brush up on their techniques or share treatment strategies with others.

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The 2nd Annual Career Fair featured 10 companies looking to recruit DOs, including two who also exhibited.

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Eleven DOs received OPSC Awards.

OMT Treatment Education Sessions returned, with 8 hours of open education times available for those wishing to brush up on their techniques or share treatment strategies with others.

See page 21 for a list of those who volunteered their time as instructors.

Members were active beyond the general educational sessions and the OMT Treatment Sessions, too. Six different committees met during the Convention this year, dealing with topics ranging from educational programming at future OPSC events to student and resident issues to broad policy goals for the association. If you would like to become more active in OPSC, committees are a great way to do that.

WesternU/COMP students once again showed up in force, with 27 student club members attending. Student volunteers could be seen at registration, in the exhibit hall, and at various committee meetings. OPSC thanks outgoing Student President David Lee, OMS II and incoming Student President Tyler Owens, OMS I for coordinating the student volunteers under the direction of Alan Cundari, DO.
Alesia J. Wagner, DO, FACOFP was recently inducted as President of the Osteopathic Physicians & Surgeons of California (OPSC). Dr. Wagner was sworn into office on Saturday, February 9, 2013 during the formal President’s Banquet held at the Hyatt Regency Mission Bay in San Diego, California. Ray Stowers, DO, President of the American Osteopathic Association, presided over the induction ceremony.

Dr. Wagner is a 1983 graduate of the University of Osteopathic Medicine and Health Sciences, College of Osteopathic Medicine, now Des Moines University. Board certified in Family Practice, she completed a rotating internship at University of Medicine and Dentistry of New Jersey, Kennedy Memorial Hospitals.

Dr. Wagner is an Assistant Professor of Family Medicine at Touro University and was previously Regional Medical Director for US Healthworks in Los Angeles, Orange County, and the Inland Empire. Prior to that, she was in private practice at Total Family Care in North Las Vegas, Nevada and served as adjunct clinical faculty at Touro University and Western University.

Immediate Past President of the California Chapter of the American College of Osteopathic Family Physicians (ACOFP), Dr. Wagner was designated a Fellow of the ACOFP in 2002 and was selected as its 2012 Family Physician of the Year. Dr. Wagner has had numerous media appearances.

As President of OPSC, Dr. Wagner will be addressing significant issues affecting the osteopathic profession, including the proposed ACGME joint residency accreditation, legislative scope of practice battles, and implementation of the Affordable Care Act.

One of the new activities occurring during this year’s Convention took place on Thursday night. The 1st Annual Women’s Reception welcomed female DOs (and men as well) with a forum to connect and discuss issues they face in their chosen profession as female practitioners. Items discussed, formally or informally, included topics such as how to get more women into osteopathic medicine, how to balance work and home life, and who within OPSC’s membership could act as mentors and be a network of support for anyone who felt they needed support. Please join OPSC in thanking the leaders who provided full funding for this inaugural event:

- Rachel Bratlie, DO
- James Huang, DO
- Geraldine O’Shea, DO
- Gregory Pecchia, DO
- Randall West, DO

Another exciting new feature of the OPSC Annual Convention is the video recording of the educational sessions, which was done for the Saturday sessions. This represented a key first step toward OPSC building an online library of presentations that DOs can access on demand. It also helped OPSC move toward the ultimate goal of broadcasting the Convention live online for CME credit. Look for this piece to be expanded at the 2013 Fall Conference as well as next year’s Convention.
New Officers & Board Members

Please welcome the newest officers and Board members of the Osteopathic Physicians & Surgeons of California:

**President-elect David Connett, DO**
- Specialty: Family Practice
- Practice Location: Pomona
- OPSC Regional Affiliate: Los Angeles County
- Medical School: WesternU/COMP - 1984

**Vice President John Kowalczyk, DO**
- Specialty: Urology
- Practice Location: Los Angeles
- OPSC Regional Affiliate: Los Angeles County
- Medical School: MWU/CCOM - 1989

**Board Members (2013 – 2016)**

**Robert Husband, DO**
- Specialty: Emergency Medicine
- Practice Location: San Diego
- OPSC Regional Affiliate: San Diego
- Medical School: WesternU/COMP - 1986

**Virginia Johnson, DO**
- Specialty: Neuromusculoskeletal Medicine/OMM
- Practice Location: Santa Monica
- OPSC Regional Affiliate: Los Angeles County
- Medical School: WesternU/COMP - 1998

**Glenn Thiel, DO**
- Specialty: Family Practice/OMM
- Practice Location: Grass Valley
- OPSC Regional Affiliate: Sacramento
- Medical School: WesternU/COMP - 1995

Mark Your Calendars!
The 2013 Fall Conference will be held August 30th – September 1st in Monterey this year. And the next Annual Convention is booked for February 5-9, 2014, again at the Hyatt Regency Mission Bay. Watch the OPSC website (www.opsc.org) for more information about both programs as well as other OPSC activities.
And the Honors Go To...

Ethan Allen, DO receives Special Recognition Award

Alan Cundari, DO accepts Special Recognition Award on behalf of Clinton Adams, DO

William Henning, DO, receiving award recognizing him as outgoing President of OPSC

James Huang, DO Physician of the Year Award

Robert Husband, DO Rookie of the Year Award

Alan Menkes, DO Lifetime Achievement Award

Minh Nguyen, DO Rookie of the Year Award

Alesia Wagner, DO Convention Chair Appreciation
Thank You to OMT Volunteers

On behalf of Virginia Johnson, DO, OPSC recognizes those DOs who took time out of the busy Annual Convention schedule to volunteer as Educating Physicians for the Osteopathic Diagnosis and Treatment Education Service sessions.

- Alexandra Myers, DO
- Immanuel Hausig, DO
- John Branch, DO
- T. Scott Smith, DO
- Ethan Allen, DO
- Clarence Nicodemus, DO

And, of course, a special thank you to Dr. Johnson for her time in coordinating the OMT Service sessions. Without her efforts, these sessions would not come to fruition.

OPSC Board Update

The OPSC Board of Directors met on February 6 and February 10, 2013 at the Hyatt Regency Mission Bay in San Diego, and took the following actions:

- Reaffirmed support for the AOA to continue negotiations on a unified ACGME residency accreditation system
- Committed to regular communication with OPSC members about the unified residency accreditation system
- Authorized funding of inaugural activities for Norm Vinn, DO, incoming AOA President
- Selected David Canton, DO as Treasurer
- Affirmed Alesia Wagner, DO’s appointment of committee chairs
- Learned that OPSC membership increased 16% last year
- Received a report on the success of the Member-Get-A-Member campaign
- Selected Geraldine O’Shea, DO as Chair of the California delegation to the 2013 AOA House of Delegates
- Authorized Emeritus members of the OPSC Board to participate in executive sessions
- Changed OPSC’s AOA House of Delegates policy to consider licensure restrictions
- Approved Paula Crone, DO, COMP’s Interim Dean, as an Ex-officio member of the OPSC Board of Directors
- Authorized installation of tenant improvements in the headquarters building
- Supported the nomination of Robert Juhasz, DO as President-elect of the American Osteopathic Association
Do You Know All the Things You Can Do Through Your Members Portal Page?

You can also, by clicking on the Professional Development link on your portal page, view/download all of your earned CME certificates.
Most importantly, our Board and our Education Committee are committed to CME development that will help our California DOs of all specialties maintain licensure and certification. We already enjoy very successful conferences. We will be THE STATE to get your AOA Category 1-A CME.

Some of you may have seen some emails regarding the sunset hearing that raised the question of maintaining separate licensing boards. In other words, should we keep the OMBC (Osteopathic Medical Board of California) separate from the MBC (Medical Board of California)? We have had a number of members and non-members send comments via our website and email on this topic. At this time, OPSC does continue to support the maintenance of a SEPARATE osteopathic licensing board. This is consistent with the position of the AOA, as well. While the majority of states do not have separate boards, the states with separate boards share a strong legislative presence with their allopathic brethren.

Scope of Practice is again in the “cross-hairs” — and OPSC is vigilant in monitoring the issues and having a presence at the discussions. OPSC Immediate Past President William Henning, DO and Executive Director Kathleen Creason have held several proactive meetings with the Nurse Practitioners about their legislative efforts to expand their scope of practice. These meetings have been very positive. Our legislative advocacy group has made us aware of new legislation being authored by Senate Health Committee Chair Ed Hernandez, OD. Our OPSC Legislative Committee, led by Chair Minh Nguyen, DO and Vice Chair Atul Bembi, DO, held an interim call to discuss this issue. The committee has decided to establish a sub-committee to guide OPSC’s involvement in the NP Scope discussions. There will be a lot of opinion and discussion on this topic. I am truly confident that the osteopathic physicians in California will put the interest of our PATIENTS first.

We are all so proud of California’s “Native Son,” Norm Vinn, DO, as he ascends to the Presidency of the AOA in July.

As you can see, we are BUSY! But, we do need your help! If there is a committee that has a special interest for you, please let me know. Our success as a profession depends on each and every one of us doing what we can to take our message and share it. At my inaugural speech, I made a request of all the DOs in attendance. I would like to share my request with all of you. I am asking every osteopathic physician in California to ask two people each month if they know what a DO is. Ask a patient…a family member…a friend…the waitress/waiter at your favorite restaurant…and if they do not, give them your two-three minute answer. Imagine what this grassroots effort to spread our message would do! I am confident that we can make the California the BEST informed state about THE DIFFERENCE A DO MAKES!

I look forward to this year as your President. Please do not hesitate to contact me for any reason at awagner@opsc.org. Thank you for your trust and support!
2013-2014 Committee Rosters

**Administrative Oversight**
Alesia J. Wagner, DO, Chair  
David A. Connett, DO  
William W. Henning, DO

**Awards**
William W. Henning, DO, Chair  
Lionel B. Katchem, DO  
Mark D. Schneider, DO  
Alesia J. Wagner, DO

**Budget & Financial Review**
David Canton, DO, Chair  
Rachel Bratlie, DO, Vice Chair  
David A. Connett, DO  
William W. Henning, DO  
Lionel B. Katchem, DO  
John J. Kowalczyk, DO, FACOS  
Abraham Pera, DO  
Alesia J. Wagner, DO

**Bylaws**
Gary A. Gramm, DO, Chair  
Blake Wylie, DO, Vice Chair  
Ethan R. Allen, DO  
William W. Henning, DO  
Donald J. Krpan, DO  
Mark D. Schneider, DO  
Alesia J. Wagner, DO

**Education**
Wadsworth H. Murad, DO, Chair  
Richard Mack, DO, Vice Chair  
Brooke Alexander, DO  
David A. Connett, DO  
Mohammad Jamshidi-Nezhad, DO  
Lionel B. Katchem, DO  
John J. Kowalczyk, DO, FACOS  
Steve S. Lee, DO, FACR  
Kenneth J. Lossing, DO  
Muhammad Rahmi Mowjood, DO  
Mark D. Schneider, DO  
Alesia J. Wagner, DO  
Stephanie Lynn White, DO  
David Wojciechowski, DO  
Blake Wylie, DO

**Ethics & Peer Review**
James B. Roth, DO, Chair  
John Battalino, DO  
Kimberly Byers-Lund, DO  
Robert Calvert, OMS  
Donna M. Cashdan, DO  
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Robert P. Chang, DO  
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- Louis Ho, DO, Vice Chair
- Jannelle Aquino, OMS
- Tracy Bigelow, DO

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- Tracy Bigelow, DO
Did you have a profession prior to medical school?
My undergraduate degree is in Economics. My profession prior to medical school was in commercial real estate in Los Angeles and Portland, OR. During my real estate career, I was initially involved with leasing and sales of Downtown Los Angeles office space, later moving into development land sales and as an institutional real estate investment specialist.

Why did you choose to become an osteopathic physician?
I decided to apply to medical school during the economic downturn of the late ‘80s when real estate development went into a complete stand still due to the recession and inflation. As I reviewed schools, I came across osteopathic medicine. I was completely drawn to the concept of treating the person as a whole and the unavoidable link of the mind, body and spirit. In addition, if you are going to go to medical school, why wouldn’t you want the additional training in OMT? It’s an extra set of tools in our bag of tricks to treat patients. Those skills have been incredibly valuable in helping patients and growing my practice.

Do you have relatives in the medical profession?
No; as far as I know, I’m the first in the family to graduate college.

Which of your professional accomplishments/activities are you most proud?
I think starting my solo practice. I did not buy a practice; it was built one patient at a time. I will never forget my first patient chart: we had to keep it standing up in the empty chart rack with two book ends. When I sold the practice, I had over 4,000 active charts. I started the solo practice at a time when many solo and small group practices were being bought by hospital networks similar the current business environment.

During your medical training, was there a uniquely osteopathic experience that made an impact on you?
I think attending the AOA House of Delegates as a student representative showed me the passion so many have for our profession.

Who was your most memorable patient?
I don’t know that I can pick one. I have watched patients struggle in life and with illness that broke my heart. I have had patients that were unbelievably inspirational and ones that taught and gave me insight into life far greater than I ever gave them. That’s the memorable gift of medicine.

How do you incorporate Osteopathic Principles of Practice in your medical care?
I truly believe in treating the person as a whole and becoming an important part of our patients’ health and well being. I have developed a relatively healthy and active population that allow me to use OMT in about 15-20% of my practice on any given day.
Why did you choose to practice in California?
The average temperature in San Clemente is 77 degrees, and I have a four-mile commute to my office. I can see the ocean from my exam rooms, surf at lunch when the swell is up and there’s a SouthWest Hemi, man!

Why are you supportive of OPSC?
See “How can we make our profession better?”

What are your hobbies?
Just about anything in or on the water/ocean.

What are your life goals?
That’s too deep a question for me. Ask me tomorrow and it will be a different answer than today.

How can we make our California profession better?
I was very involved in our profession with OPSC and OPSO during medical school and residency. Starting my practice was very stressful and time consuming and my involvement with the profession declined. We are in a period of tremendous change in the way we will ultimately practice medicine. I believe that working together and sharing information and professional experience will be invaluable as we navigate the future changes in medicine. I believe it’s important for all of us to reconnect with colleagues both professionally and personally. Our collective focus can impact the direction of health care in California and nationally.

Are there any words of wisdom you'd like to share with osteopathic physicians in training?
I know it's difficult to think about anything but the next test. Don’t ignore learning about the “Business of Medicine” – you can’t avoid it. We are in revolutionary times in medicine with EHRs, HIEs, Patient Portals, ACOs, Meaningful Use, P4P, Quality Metrics, etc. You will be a more valuable future prospect to employers if you understand practicing medicine in this new environment.

Have you renewed your OPSC membership?
OPSC’s membership renewal period is in full swing! Don’t let the opportunity to continue your membership slip away. Renewing has never been easier. Simply log on to www.opsc.org and click the Renew Now link on the OPSC homepage. Once you have clicked this link, you will be requested to sign-in using your username and password and to pay, via credit card, through our secure site.

Once you have renewed, we would appreciate it if you take a moment to update your contact information by clicking the “My Info” button on the top of payment confirmation page. OPSC’s directory is utilized daily by the public and fellow physician members to locate osteopathic physicians in their area. Please make sure that your contact information is complete and up-to-date.

We’re Social!
Follow us on Twitter (https://twitter.com/CALIFORNIADO)
or friend us on Facebook (http://www.facebook.com/osteopathic.physicians.ca)
On January 1, 2013 the College of Osteopathic Medicine of the Pacific experienced a change in leadership with Clinton E. Adams, DO stepping down as Dean and taking a sabbatical with the American Association of Colleges of Osteopathic Medicine to work on his fellowship with the American Osteopathic Associations and the Accreditation Counsel for Graduate Medical Education in the consolidation of residency training programs.

Paula M. Crone, DO, who is the Vice President of Oregon Campus Operations, assumed the role of Interim Dean on January 1, 2013. Dr. Crone is the first graduate from the College of Osteopathic Medicine of Pacific to have assumed this leadership position in the history of Western University of Health Sciences. Her wealth of experience working with the Commission of Osteopathic Accreditation on the development of COMP-Northwest as well as her experience in the curricular development of COMP has been invaluable during this time of transition. Prior to Dr. Crone’s appointment as Interim Dean, she was the Executive Associate Dean of COMP-Northwest and the former Program Director of the family medicine residency at Eastmoreland Hospital in Portland and was on the Board of Directors of FamilyCare, Incorporated.

Dr. Crone appointed David A. Connett, DO as Vice Dean. Prior to Dr. Cornett’s appointment as Vice Dean, he served as the Associate Dean of Clinical Affairs and former Assistant Dean of Postgraduate Education and Development. Dr. Connett has been the Medical Director of the COMP Clinic System since his arrival at Western University six years ago. Dr. Connett is the President-elect of the Osteopathic Physicians and Surgeons of California and an alumnus of Western University of Health Sciences.

Upon the recent ACGME and AOA match completion, COMP is very pleased to announce a 99% placement in postgraduate residency positions.

The College of Osteopathic Medicine of the Pacific received 5029 applications to the Pomona, CA campus for 220 positions and 2606 applications for the Lebanon, OR campus for 100 positions.

On May 4, 2013, Western University of Health Sciences will sponsor the COMP 6th Annual Alumni Continuing Medical Education. This annual event features many of COMP’s faculty members and clinicians and provides an opportunity for alumni to interact with and mentor current medical students.

On May 2, 2013, the Osteopathic Medical Board of California will have its quarterly business meeting to include deliberations regarding the licensure of California osteopathic physicians on the Western University of Health Sciences campus. This will provide an educational opportunity for our students and a convenient alternate meeting place for the public at large.
The 2013-14 academic year has arrived quickly carrying much momentum from the previous year! Thanks to last year’s club officers, especially past President David Lee (OMS II), a smooth transition was made into the new year.

2013 began with more than thirty WesternU students attending the 52nd Annual Convention in San Diego. At the conference many students participated in committee meetings, volunteered at the front desk, worked at exhibition booths, and attended the President’s Dinner where they shook hands with several OPSC Board Members.

Following the annual conference in San Diego, a number events transpired:

- Representative Gloria Negrete McLeod visited WesternU students preparing to attend AOA’s DO Day on Capitol Hill. Many topics were discussed including GME funding, graduate student loan debt, California healthcare reform, and physician repayment. The Congresswoman gave advice to students lobbying for the first time telling them to know the issues and to be specific. When the Congresswoman was asked what WesternU students could do to best serve the community she replied, “You’re already doing it.” She was speaking in reference to Montclair Clinic, a health clinic worked by residents and WesternU students providing health services at a sliding cost to individuals lacking health insurance.

- Twenty-seven WesternU students attended AOA’s DO Day on Capitol Hill in Washington, D.C. Students met with various members of Congress and their staff to lobby for the Medicare Physician Payment Innovation Act of 2013 and The Resident Physician Shortage Reduction and Graduate Medical Education Accountability and Transparency Act. The students had a great time meeting their legislators and enjoyed touring D.C.

- OPSC student members volunteered their time tutoring at-risk youth through Project Sharing and Caring (PSC). A non-profit program put on through a local community church, PSC provides free tutoring and mentorship for elementary and high-school students in the Pomona public school system. By addressing gaps in the curriculum that a student might miss during school hours, WesternU students have built meaningful relationships with youth who might otherwise fall behind in their classes. Ryan Nguyen, a first-year WesternU osteopathic medical student and regular PSC volunteer, puts it best, “I have a great time just spending time with the kids I tutor on Wednesday. We go over math problems they didn’t understand during school, but we also have a chance to talk about their lives, what they’re excited and worried about, and what they want to do in a few years. It’s a refreshing break from studying and a great way to give back to the local community.”

- Twenty-one students have volunteered to be an OPSC student committee member. There are now students on eight different OPSC committees. In related news, about half a dozen students are being led by Rachel Bratlie, DO in OPSC’s newly formed Social Work Group which aims to expand OPSC’s social media presence via Facebook, Twitter, and LinkedIn.

- WesternU’s OPSC club has made its presence on WesternU campus by holding a fundraiser and taking part in WesternU’s annual Club Extravaganza. The fundraiser involved selling burritos from a local business while talking about the purpose of OPSC with fellow peers. The club’s presence at the Club Extravaganza allowed people inside and outside of the osteopathic community to learn about OPSC. Hundreds of WesternU students and faculty from other departments, including veterinary medicine, optometry, nursing, and physical therapy attended the event. Many learned about OPSC for the first time.

With the invaluable experiences of this spring coming to a close, we have begun to finalize our summer plans. We anticipate sponsoring the AOA President’s campus lecture concerning the AOA and ACGME merger, participating in OPSCs Legislative Day on May 6th, and increasing our student budget by fundraising through a creative summer project. To students looking to become involved in the WesternU OPSC club please contact us today at OPSCclub@westernu.edu!
Touro Update

Campus News
For the fourth consecutive year, TUCOM-CA was recognized for meeting one of its key missions, to provide quality primary care providers. TUCOM-CA was once again ranked 10th nationally by U.S. News and World Report for having 55.2% of our graduates (from 2010-12) entering primary care residencies.

The Student Run Medical Clinic continues to offer free medical advice and care to those most at need in our community. This initiative embodies the inter-professional spirit of TUC and its commitment to the community.

TUC hosted the Teen Life Conference on-campus, which is aimed at local high school students to spread the message that it’s never too late to embrace a healthy lifestyle. The 8th Annual Teen Life Conference allowed teens and families to address relevant health care issues and post high school career options through educational lectures, health screenings, interactive informational booths and physical fitness activities.

Student News
Student Doctors Patrick Wu and Jonathan Siu co-authored “A Brief Guide to Osteopathic Medicine, For Students, By Students.” This is a comprehensive, 32-page guide designed to help aspiring physicians understand osteopathic medicine and the path to becoming an osteopathic physician. This Guide is available by PDF download free of charge. The link to the site: http://www.aacom.org/resources/bookstore/Pages/BriefGuide.aspx

Alumni News
Alumnus Gerard Balthazar, DO, is first author in a JAOA manuscript on OMT on post-surgical ileus.

Department Updates
Congratulations to Patricia Rehfield DO, MPH on her promotion to Associate Professor.

Research Updates
The first quarter of 2013 brought exciting news and activities for our Research Department with the following publications:

- “Acceptability of Fluzone Intradermal Vaccine to Patients and Vaccine Administrators” by James E. Foy, DO; Tami Hendriksz, DO; Philip Malouf, MD; and Allison Tobin, OMS III in the JAOA
- “The Evolution or Revolution of Statin Therapy in Primary Prevention: Where Do We Go From Here?” By Patricia Rehfield, DO; Colin Kopes-Kerr, MD; and Michael Clearfield, DO in Current Atherosclerosis Reports

Dr. Clearfield was selected as a member of the steering committee for the NIH funded Cardiovascular Inflammation Reduction Trial (CIRT), which is recruiting over 400 sites nationally and in Canada, of which over twenty will be osteopathic sites, investigating the ability of low dose methotrexate to reduce recurrent cardiovascular events.

COM News
The selection of Dr. Walter Hartwig as Associate Dean for Academic Affairs allows Gregg Lund, DO to now assume the position of Senior Associate Dean within the COM which then allows Abraham Pera, DO, the current Senior Associate Dean, to transition back into the Primary Care Department, where he will be able to once again focus on his passion to teach.

Sara Modlin, OMS I demonstrates an osteopathic screening exam for pre-meds attending the Pre-Med Conference.
Touro Students’ Report

Courtney Stallings, OMS II, Student Club President

With nearly 200 aspiring pre-medical attendees from within the San Francisco Bay Area and as far away as southern California, as well as out-of-state participants, Touro University California’s SOMA Pre-Medical Conference on Sunday, February 17th was a great success.

In the morning, we heard speeches from our Dean, Dr. Michael Clearfield; OMM Professor and Department Chair Dr. John Glover; and AACOM Associate Director of Application Services Gina Moses. Additionally, applicants were able to experience different facets of their potential osteopathic journey: the application process, the student experience, and beyond.

In the afternoon, students attended three different Q&A sessions, including a panel of Touro’s admissions committee and faculty, and panels of both traditional and non-traditional current medical students, as well as a faculty-supervised OMM demonstration and anatomy lab tour.

All of this was made possible by the support from OPSC, SOMA, the 14 TUCOM-CA faculty and administrators, and 60 TUCOM-CA students who volunteered at the event.

Our conference was not solely represented by Touro University - California; we had representatives from the A.T. Still University campuses, Midwestern University’s AZCOM, Western University, the LECOM campuses, KCUMB, Campbell University, and our sister school, Touro University Nevada. With attendees ranging from college freshmen to graduates and post-baccalaureate students, our feedback was overwhelmingly positive.

This conference is an event we truly believe we can and should continue to host in the future and hopefully expand elsewhere in the years to come.

Color and Healing: The Power of Color in the Healthcare Environment

Continued from page 15

Yellow – Optimistic, warm, inviting
Yellow stimulates the intellect and makes us alert and aware yet can fatigue the eye. In the body it responds to chest, heart and lungs.

Orange – Energetic, joyful
In the body, orange is associated with circulation and the nervous system. It can have a tonic effect that is as powerful as Vitamin C. There are studies linking orange to increasing oxygen supply to the brain.

Red – Bold, exciting
It is shown that red releases adrenaline, which elevates blood pressure and quickens the heartbeat. With regard to the body, it is associated with the spine and motor skill activities.

Pink – Soothing, caring and affectionate
Pink is a happy color and can often be lighthearted. If it is bright, it can stimulate energy and respond like red.

Purple – Meditative, spiritual
Purple helps to develop insight and perception. Violet in the body corresponds to the top of the head, the nervous system and cerebral activity. It often supports nonverbal activity

Green – Balance, harmony and renewal
When the eye perceives green, it makes no adjustment; thus green is thought to be restful and healing. In the body, green relates to the heart, lungs, circulatory system and the complete chest area.

Blue – Calm, relaxing
Blue lowers blood pressure and encourages deep breathing as it relaxes muscles and the mind. It is a color for communication. In the body, it correlates with the eyes, ears and nose.

Caitlin Harris, OMS II, Sukhmani Dhaliwal, OMS I, and others explain the principles of osteopathic evaluation to pre-meds attending the Pre-Med Conference.
Continuing with the Medi-Cal theme today, I attend a meeting with the California Medical Association and other providers this afternoon to discuss next steps in fighting the 10% Medi-Cal cuts. The Governor’s proposed budget includes not only a plan to cut Medi-Cal rates with the upcoming budget, but also to “claw back” funds already paid to physicians and other providers, dating back to 2011! With California already an abysmal 47th in the nation in Medicaid payment rates, and millions of new Medi-Cal patients anticipated next year with ACA implementation, an additional cut in untenable. OPSC expresses our strong commitment to fight both the prospective and the retroactive cuts.

After the meeting, I’m back in my office, keeping a few projects moving along. I’m so appreciative of OPSC staff members Cassandra Mallory and Karl Baur for managing OPSC’s projects and supporting member services. Their work in the office allows me to get out and ensure the osteopathic profession is represented in all of the appropriate forums. Around 5:45 p.m. the janitorial crew arrives, reminding me that it’s time to wrap up the work day and get ready for my Tuesday night volleyball match.

**Wednesday**

No meetings Wednesday morning, which allows me to get some work done in the office. Because our staff is small in number, we all pitch in to get things done. This morning, I’m working on OPSC’s strategic plan. William Henning, DO, last year’s President, put a renewed focus on strategic planning, requesting that all committees identify activities which support the plan. This year’s President, Alesia Wagner, DO, is very engaged in this endeavor, working closely with the committees to ensure we achieve the stated goals. I’m taking this opportunity to review the progress of the plan details and identify areas that need some attention. The strategic plan is our touchstone, helping us to make sure we stay focused on the areas that provide most value to our members.

While the morning provided a quiet focus, the afternoon is a different story. It starts off with a lunchtime conference call of the osteopathic state executive directors who are spearheading development of a national on-line CME platform for DOs. We’re in the final stages, just refining a few last details. OPSC video recorded a portion of the recent Annual Convention, so we’re poised to be one of the first states to offer on-line osteopathic CME on-demand. It is very exciting to be able to offer a convenient, cost-effective alternative for physicians who have difficulty getting to live meetings.

Next, I swing by the Sacramento airport to pick up Dr. Henning. He’s arriving in town for a state healthcare workforce committee meeting, but he came in early to join our legislative advocates and me for a meeting with Senator Ed Hernandez’ policy consultant. Senator Hernandez is the powerful Chair of the Senate Health Committee, and he’s pushing hard this year to find creative solutions to meet expanding healthcare workforce needs. We have concerns that some of these ideas may place patients in harm’s way, so we want to ensure he hears the osteopathic perspective. The meeting is productive, concluding with a commitment to engage OPSC in actively identifying reasonable solutions.

Dr. Henning and I come back to the OPSC office to meet with representatives from the Nurse Practitioners’ association. We have a cordial meeting, as they discuss their desire to broaden their scope of practice. They assure us they know the limits of their abilities and are not seeking independent practice rights. Senator Hernandez subsequently introduces legislation which proposes… you guessed it… independent practice rights for nurse practitioners.

After dropping Dr. Henning off at the site of his workforce meeting, I zip on over to the airport, as I’m making a quick trip down to Ontario to attend the San Bernardino County Osteopathic Medical Association dinner meeting. James M. Lally, DO has been coordinating these meetings for years but agreed it is time to bring in some new leadership. The group enjoys a nice dinner hosted by Dr. Lally, an followed by an educational talk, and then they hold an election, voting Ali Heidari, DO as the new SBCOMA President. I stay and chat for a few minutes, but have to run to catch the last flight back to Sacramento. The plane touches down at 11:00 p.m.

**Thursday**

My regular morning workout goes by the wayside today due to last night’s late return. I’ll occasionally try to squeeze in a lunchtime cycle class on days like this, but the timing doesn’t work today. No dessert for me today! The morning starts with a meeting at the Department of Justice (DOJ) to talk about their proposal to fund CURES, California’s prescription drug monitoring program. While we agree that prescription drug abuse is a serious problem, we are vehemently opposed to taxing physicians to help fund the tracking program. Instead, we suggest that, because this issue affects the general public, CURES should be funded by general fund monies. DOJ staff is skeptical about the ability to consistently secure general fund monies for the program, but agrees to pursue the possibility. We later discover that CMA has had a very similar conversation with the DOJ.

Following the DOJ meeting, I travel to Touro University in Vallejo. CMA’s incoming President has asked to meet with COM Dean Michael Clearfield, DO, and I’ll be joining them. It’s rewarding to see the value...
CMA places on the osteopathic profession through their presence on the osteopathic medical school campuses. Some have expressed concern about the allopathic and osteopathic professions drawing too closely together, so we remain attuned to these interactions.

Later in the afternoon, I have a few minutes back in the office, so I take some time to work on a presentation I’ve been asked to make at the AOA’s Advocacy for Healthy Partnership meeting. I’m very honored to have been selected as a presenter at this program for Presidential officers and executive directors from throughout the U.S. The topic is leadership development; I give some thought to the processes that we employ to identify and develop strong leaders. OPSC is very fortunate to have outstanding physician leaders, as evidenced by the number who have risen through the ranks at the national level — including AOA’s incoming President, our own Norm Vinn, DO.

I also catch up via telephone with Konrad Miskowicz-Retz, PhD, AOA’s Director of the Department of Accreditation. Konrad is serving as the osteopathic representative on the task force charged with assessing podiatric education and training in California, as the podiatrists seek to obtain designation as physicians and surgeons. During our conversation, Konrad emphasizes the importance of measuring competence, rather than simply indicating that coursework on specific topics are required.

To cap off the afternoon, I receive a call from the Vice President of Noridian Administrative Services, the new Medicare contractor for California. He indicates that he was advised by CMS that OPSC is an important organization to dialogue with about the transition from Palmetto GBA. I’m very pleased to have this contact, as we often receive requests for assistance from members having trouble obtaining payment from Medicare, particularly during times of transition. It’s also reassuring to know that all of our advocacy work is paying off — regulatory agencies are understanding the importance of DOs in healthcare!

This evening I attend a legislative fundraiser for Assemblymember Richard Pan, MD, hosted by the MICRA coalition, Californians Allied for Patient Protection (CAPP). It’s a gorgeous late afternoon, so I decide to walk the 10 blocks to the event, held near the State Capitol (which reminds me yet again that purchasing our new office building was a great decision). I enjoy catching up with Dr. Pan. As the Chair of the Assembly Health Committee, he brings a deep level of healthcare knowledge to the Legislature that is so valuable.

The event wraps up at 6:30, so I head home to enjoy an evening with my family, including the one who’s truly ecstatic to see me walk in the door — “Buster,” my new yellow lab puppy. Nothing like that unconditional love!
Monterey Is Calling You!

I would like to officially extend a personal invitation for you to join your osteopathic colleagues in Monterey, California for our 24th Annual Fall Conference, August 30th – September 1st. You might notice that, this year, the Conference is happening a little earlier than usual. Monterey is a world-class destination, which means many groups compete for space during the beautiful fall season. A number of large events in Monterey in September have prompted us to move to new dates, though the change is not without benefits. For example, the InterContinental agreed to reduce the guest room rate even below last year’s rates. Our hope is that you will be able to take advantage of the holiday weekend to stay a bit longer and enjoy a short vacation – enjoy the beautiful ocean-front community, visit the Monterey Bay Aquarium, or sample a few extra restaurants.

We will be offering approximately 22 hours of category 1-A CME over the course of the Conference, including:
- Town hall meetings on the ACGME unified residency system and OCC
- Updates on dual eligible patients
- Lectures on electronic records and billing concerns for osteopathic evaluation and management
- Clinical topics such as Opioid Use, HIV, and Immunology

I look forward to welcoming you to this great City by the (Monterey) Bay.

John Kowalczyk, DO
Fall Conference Program Chair
**Make Your Room Reservations Early!**

OPSC has obtained a special conference rate for room accommodations at the InterContinental The Clement Monterey located at 750 Cannery Row, Monterey, CA 93940-1489. Room rates are $210 single/double occupancy (inland view rooms only).

Reservations must be made by **Wednesday, July 31, 2013**. To make your room reservations please contact the InterContinental directly by phone: (888) 424-6835 or online at www.opsc.org. To receive the conference room rate please inform the hotel that you are with the OPSC conference when making your reservations.

**cme Information**

OPSC anticipates that the AOA Council on Continuing Medical Education will approve this program for 22 hours of AOA Category 1-A CME Credit. Approval is currently pending.

**Program Schedule**

**Friday, August 30**
- 12:30 - 1:00 pm Opening Session
- 1:00 pm - 6:30 pm CME sessions
- 6:30 - 7:30 pm Welcome Reception

**Saturday, August 31**
- 7:00 am - 6:00 pm CME sessions
- 6:30 pm - 8:30 pm Dinner CME program

**Sunday, September 1**
- 7:00 am - Noon CME sessions

Updated schedule and session information will be available on the OPSC website (www.opsc.org) as it is confirmed.

**Enjoy Monterey!**

Anchored by San Carlos Beach on one end and the Monterey Bay Aquarium on the other, Cannery Row stretches along the Monterey Bay National Marine Sanctuary and offers unmatched access to natural marvels. There is no better place to explore the bay, whether you choose to peer into coastal tide pools, watch sea lions splash, kayak along kelp beds or dive at one of several walk-in scuba spots. The Coastal Recreation Trail, which connects points along Cannery Row and beyond, provides scenic views and wildlife watching opportunities, and guests can get acquainted with jellies, sea otters and other underwater wonders at the aquarium.

Register online at [www.opsc.org](http://www.opsc.org)
REGISTRATION FORM

24th Annual Fall Conference  ●  August 30 - September 1, 2013
InterContinental The Clement Monterey
750 Cannery Row, Monterey, California 93940

Name                                                                 AOA Number

☐ Home  ☐ Work  Street _____________________________________________

City ___________________________ State _____________ Zip _____________

Phone __________________________ Fax ___________________________

Email address ____________________ Specialty _______________________

☐ Check here if we may provide your email address to Fall Conference Exhibitors.

College __________________________ Year of Graduation

EARLY REGISTRATION FEES
The deadline for pre-registration is July 31, 2013. Registrations received after the deadline and on-site registrations will be subject to a $50 fee and are accepted on a space available basis. Guests (including children over 4 years of age) must purchase tickets to participate in meals. Please make sure to check the appropriate registration category:

☐ Guest/s  $95 each

Number of Guests ___________________ Guest Name/s ______________________

Special Needs or Dietary Requests

RSVP FOR SATURDAY EVENING DINNER LECTURE:
☐ Yes, ___________ adults will be attending  ☐ No, I will not be attending

REGISTRATION FEES

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MEMBERSHIP FEES:

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All registrations after August 23, 2013 must be submitted at the OPSC registration desk on-site. Onsite registrations will be accepted as space permits. Rates may be higher.

1. Out of state registrants must provide membership verification of your home state osteopathic association. California physicians must be a member in good standing with OPSC. 2. Must be in an accredited internship/residency program, verification is required. 3. Meals and CME credits not included.

Syllabus will be provided online prior to the conference for download and a jump/flash drive will be provided onsite at no charge. Complimentary internet connectivity will be provided in the meeting room. Please bring your laptop! Hardcopies of the syllabus are available for pre-order only for $25 each.

PAYMENT INFORMATION

☐ Check enclosed  ☐ Visa  ☐ Mastercard

Card Number _____________________________

Exp. Date ___________ CVV# _____________

Name on Card ___________________________

Signature ______________________________

Billing address ___________________________

if different than above

$ _______ Registration Fee Total

$ _______ Guest Fee Total

$ _______ Syllabus Hardcopy ($25)

$ _______ Membership Fee Total

$ _______ Total Enclosed/Due

CANCELATIONS: All cancellation requests must be made in writing and received by OPSC no later than July 31, 2013. A $50 processing fee will be assessed for all cancellations. Registration fees are not refundable after July 31, 2013.

Mail this form to:
2015 H Street, Sacramento, CA 95811

Fax this form to:
(916) 822-5247

Register online at
www.opsc.org
To improve patient safety, you need to stay on top of best practices. That's why, as shown by the 2011 numbers above, we provide you the risk management advice you need, when and how you want it. It's why we provide industry-leading CME online and through Claims Rx, our monthly publication based on closed claims. And why we tailor solutions to help with your specific risk issues. The results include 98% policyholder retention, the highest-level CME accreditation and reduced risk for you.

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American College of Osteopathic Family Physicians - California

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AUGUST 1-4, 2013

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at the Disneyland Hotel

Registration Information
WWW.ACOFPCA.ORG
Nearly 100 years ago, Nobel Prize-winning scientist August Krogh and his wife Marie embarked on a journey to revolutionize diabetes care, driven by her needs as a diabetes patient. Today, Novo Nordisk still takes a deeply human approach to everything we do. As a world leader in diabetes care, we are in a position of great responsibility. We must continue to combine drug discovery and technology to turn science into treatments. We must prioritize research, education, and partnerships around the world to make diabetes a global priority. We must conduct our business responsibly in every way. And most importantly, we can never lose sight of the patient-centric approach that has driven our vision of innovation since our inception.

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